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ABSTRACT

This paper discusses paradoxical interventions, considering some of the structural variations among paradoxical techniques found in the treatment literature and in general, and highlighting clinical and ethical issues that are pertinent to the application of paradoxical techniques. The structuring of the theraputic paradox is discussed including the use of rationales, defined as verbal statements that conceptually link the impending directive to the overall goal of theraputic change. Categories of rationales, i.e., those that emphasize additional data gathering, and those that redefine the problem, are described and illustrated in case examples. The second component of the theraputic paradox, the directive, is described and its use is illustrated in a marital counseling situation. The follow up to the paradox, or handling client comments about the change process, is discussed along with specific suggestions for this phase of the process. Ethical considerations in the use of paradox, especially with psychotically disorganized clients, are summarized in a final section. (MCF)

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SOME CONSIDERATIONS REGARDING THE USE OF PARADOXICAL INTERVENTIONS[1]

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The purpose of my presentation is to discuss how paradoxical interventions may be most effectively designed and implemented into clinical situations, to consider some of the structural variations among paradoxical techniques that are described in the treatment literature and in general, to highlight some of the clinical and ethical issues I believe are pertinent to the application of paradoxical techniques.

The Structuring of a Therapeutic Paradox

Rationales. Although a paradoxical technique is less dependent on client cooperation than more conventional strategies, it still requires a modicum of client participation. It seems reasonable to suggest that clients will only benefit from this or, for that matter, any techniques if they perceive it as 1) something that they can do and 2) something that is consistent with the overall therapeutic objective of symptom relief or problem remission. For this reason, some type of rationale statement which lends credence or "face validity" to the unusual therapeutic demand is useful for soliciting client interest and participation. "Rationales" here are defined as verbal statements that conceptually link the impending directive to the overall goal of therapeutic change. While all paradoxical rationales create a framework for supporting a demand for performing the problem behavior, there appear to be at least two discrete categories of rationales in the paradoxical literature: those that emphasize the importance of additional data gathering, and those which redefine the "problem" sufficiently to allow for symptom continuation or exaggeration.

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[1] This paper was part of the Symposium entitled "The Use of Paradox in Counseling: Theory, practice and research," which was presented at the meeting of the American Psychological Association, Washington, D. C., August, 1982.

As an example of the first type, let's consider a provocative study by Ascher & Efran (1978). These authors monitored the progress of insomniacs in a 10-week "behavioral" treatment program to decrease sleep-onset insomnia. The standard program centered around daily monitoring of sleep-onset and intensive training in deep-muscle relaxation. At the conclusion of the 10-week program, a subgroup of these patients reported no change in their sleep behavior. At this point, the authors met with the unimproved individuals and told them that the earlier training was probably ineffective because more information needed to be gathered on the precise nature of their thoughts immediately before dropping off to sleep. In order to obtain this highly relevant data, the investigators argued, it would be imperative that, for the following week, each patient continue their daily monitoring of their sleep onset but that now they should resist the urge to sleep for as long as possible so that they could become more aware of the thoughts that immediately preceded sleep. In short, the unimproved insomniacs were now being directed to engage in their "sleep-delaying" behavior for therapeutic ends. Results were immediate, dramatic and apparently long-lasting. All members of the unimproved group reported significant decreases in sleep onset latencies over the following week. An informal one-year follow-up of the paradoxically-directed patients indicated no recurrence of sleep onset difficulties.

I designed a similar rationale in my doctoral study of the effects of paradoxical directives in the treatment of procrastination in a group of college students (Lopez & Wambach, 1982). Essentially, subjects in the paradoxical condition were informed by the counselor that their procrastination difficulties were due in large part to their "lack of awareness and understanding" of the behavior as it actually occurred. Subjects were then enjoined to set aside some

time each day during which they would procrastinate, resist any urges to study, and simply become more aware of the thoughts and feelings that occurred as they procrastinated. Again, my results also indicated support for the therapeutic effectiveness of this demand. Subjects in the paradoxical condition reported a sharper rate of improvement in their procrastination over the 4-week experiment than did a comparable subject group receiving more conventional self-control instruction (improving study habits, self-monitoring, self-reinforcement and goal-setting).

Rationales of the second variety--that is, those which redefine the "problem" sufficiently to support symptom prescription--are essentially "reframing" techniques themselves. The concepts of "reframing" and "paradox" are often discussed together. However, they are not mutually inclusive. A symptom can be "reframed" as an asset or a strength without being accompanied by any explicit demand to engage in the problem behavior. Still the two techniques are very complementary and can be used in conjunction.

For example, in my current caseload, I have a female client who compulsively picks up after both husband and kids despite the fact that she deeply resents having to do it. Her previous attempts to initiate change have been feeble, inconsistent and largely ignored. I soon discovered that my recommended strategies for enhancing her assertiveness were likewise inconsistently applied and again largely ignored by family members. Recently I suggested to her that perhaps she could not insist on change from her family because it was more important for her to protect them from the pain and disappointment that they would experience if they tried to change and failed. Her compulsive housecleaning was thus reframed as a selfless expression of love and protection and she was encouraged to continue this behavior and at the same time work even harder at lessening any demands on them. The combination of the problem reframing and the symptom

prescription proved to be an effective catalyst in breaking the previous pattern. Not only did her demands on her family escalate but as they did so did her need to "justify" the apparent turn-around now as "an even better expression of her love and concern."

Before leaving the topic of rationales it may be useful to consider paradoxical tasks that are apparently "rationale-free." Paul Watzlawick (1980), who has written extensively in the area of paradoxical communication, discusses a "Devil's Pact" format that he uses with clients whom he suspects will object to any explicit treatment rationale. Basically, in employing the "Devil's Pact", the therapist first tantalizes the client by saying that he knows of something relatively easy and harmless that the client can do to solve his problem, but that he probably would resist doing it. Moreover, the therapist suggests that this task is the only way "out" of the problem. When the client inquires about the "solution" or "why it should be effective," the therapist declines disclosure by emphasizing that a discussion of the strategy would simply mobilize his opposition to participating and that he (the therapist) would first need to receive the client's commitment to perform the task before disclosing any of the details. To heighten curiosity and anticipation, the client is usually given a week to "think about it" and "to decide" whether or not he will participate without prior knowledge of the task. Once agreement is voiced, the paradoxical instructions are given and any discussion about why they should be effective is discouraged. Instead, the client is encouraged to come up with his own rationale as to why change occurred.

The Directive. So much for rationales. The other vital component to the therapeutic paradox is the directive itself. By definition, a paradoxical directive will incorporate a demand for current behavior as opposed to new or

different behavior. The therapist directs the client to do something that he/she is already doing. The treatment literature and my own clinical experience with paradoxical interventions suggest at least three considerations when selecting the target behaviors for paradoxical directives.

To begin with, client behaviors that are reportedly "involuntary" or "uncontrollable" appear to be the most amenable to paradoxical prescription. Usually, but not always, these are the symptoms themselves (e.g. procrastination, compulsive house cleaning, sleep-onset insomnia, etc.). The prescribed behavior(s) may be one that is emitted by an individual client or part of a recurring interactive sequence between two or more clients--a sequence that is again reportedly "impulsive" or "involuntary." As an illustration of the latter, let's consider a marital counseling case involving a husband who effectively stifles his wife's criticisms of him by deftly switching the focus to some extraneous topic, a maneuver which is followed by the wife terminating her criticism and sulking passively. After the pattern becomes evident, the therapist may intervene at a later point and ask the couple to enact a typical dialogue so that he (therapist) can make some additional observations necessary for "improving his understanding of their marital difficulties" (rationale). He can then direct the couple to begin a dialogue, with the wife eventually bringing up some criticisms she has of her husband. The husband is instructed to <u>resist listening</u> to any of his wife's critical remarks for as long as possible and instead respond by trying to think up ways of <u>switching the conversation to other topics</u>. As the husband does this, the wife is forewarned that she should <u>resist any urges to confront her husband</u> and instead must <u>sit quietly and contain her frustration</u> for as long as possible. This example also illustrates the other two considerations I suspect are important in structuring the directive component of a therapeutic paradox. The first of these is that the critical problem behaviors are

specified. I suspect that vague prescriptions such as "don't change this week" or "do what you've been doing" will appear less credible and thus invite client non-cooperation. Secondly, the selected target behaviors are those that occur in the client's "natural context" as opposed to ones that are contrived by the therapist. I believe that it is most effective to take a discrete and specific behavior pattern that is currently in force or whose occurrence is strongly anticipated and to prescribe that this pattern occur at a particular time and place.

In a recent article, Omer (1982) states that the common element in all paradoxical methods is that they "decontextualize" the problem behaviors; in other words, by performing the problem under direction and in a planned versus spontaneous fashion, the problem context is changed. He suggests this contextual modification is the vehicle of change in that it alters both the function and meaning of the symptom and thus disrupts the typical reinforcement process that may be at work. This perspective further suggests that paradoxical directives which prescribe that the "naturally-occurring" problem behavior occur in a somewhat different context may be even more effective in facilitating change. Possible context modifications may include 1) increasing the frequency or duration of the symptom, 2) prescribing that it occur at an atypical location or time, or 3) insisting that the usual behavioral sequence incorporate some small but nonetheless novel element.

The Follow-Up: Handling Client Commentary and "Spontaneous Change." Most paradoxical interventions create a unique interactional context in which clients experience symptom improvement as they attempt to comply with the therapist's demands. Therefore, how the therapist responds to client feedback and to clinical results may be highly relevant to the maintenance of any observed behavioral changes. For many clients the change may be unexpected or "spontaneous." They

may be curious about their improvement and may solicit an explanation of their experience from the therapist. Writers in the paradoxical literature differ in their opinions about how the therapist should respond to "spontaneous change" and to such client inquiries. Frankl (1959, 1975) argues that changes resulting from paradoxical intention be explained in terms of the strategy's effect on anticipatory anxiety and negative expectations. Watzlawick (1980) and Haley (1976), on the other hand, assert that no explanation is really necessary and that the therapist would be best advised to respond to any and all changes with a mixture of surprise and skepticism. The advantage that I perceive in this latter approach is that, by not offering an explanation of the results, the therapist maintains firmer control over symptom management. After all, clients can reject theories as well as techniques. Therefore, the less the therapist offers in the way of explanation, the greater the burden on the client to explain and hopefully to affirm his/her own change. Moreover, by displaying a skeptical attitude over initial improvement, the therapist retains the capability of reissuing the same or similar instructions for "validation" purposes. For example, with clients who are themselves skeptical that their improvement will last, Watzlawick suggests that a "relapse prescription" may be useful in maintaining the previous change. In issuing a "relapse prescription", the therapist directs the improved client to "go back and engage in the symptom" during the following week. This directive thus anticipates the relapse and prescribes it. As such, you might consider it a "second-order" paradox.

Regardless of whether you opt to explain your procedure or not, it would seem to me that therapy time would be more productive if spent on exploring the nature and consequences of the change itself--that is, what the client did differently, how he/she felt about it, how other people responded to the change, etc.

Ethical Considerations. The essence of a paradoxical intervention, that is, the therapeutic demand that a problem behavior be performed, raises some important ethical considerations. Are there times or client problem-types where such an intervention would be either ethically contraindicated or of questionable utility? Despite the recent proliferation of writing in the area of paradoxical direction, few authors have specifically addressed this question. I believe that ethical considerations are particularly salient when the client problem involves violent, aggressive or potentially injurious behaviors. To instruct an alcoholic client to drink a fifth of booze a day appears clearly unethical in that it prescribes activity that is injurious to the client's health. This is not to say that paradoxical interventions cannot be used with alcoholics. Other alcoholism-related behaviors -- such as "denial" or "bottle hiding" behaviors -- may be quite amenable to paradoxical prescription while not jeopardizing the person's health. Other considerations center around the question of whether paradoxical directives should be used in the treatment of psychotic individuals. My reading of the clinical literature indicates that there is professional disagreement on this score. The majority of contributors have restricted the use of paradox to the treatment of neurotic, obsessive-compulsive behaviors. However, in his work with schizophrenic clients, Rosen (1953) reports success in insisting that his clients engage in "sick talk" during their therapy sessions. He then competes with them by concocting delusions that are even more elaborate. Still, the paucity of controlled outcome research evaluating paradoxical techniques, especially with regard to their use with psychotically-disorganized patients, underscores the need to use caution in employing such interventions with this population. Finally, I suspect that paradoxical techniques would be of questionable utility in cases involving acute situational stress where the symptoms may well be temporary and not part of any chronic problem pattern.

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